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ABSTRACT

This project originally began as a direct result of counselor activities and difficulties in the Model Cities areas. The Providence and Pawtucket Model Cities areas proved to be a source of frustration for the counselors involved due to the multiplicity of problems found there and the inadequacy of the usual Division of Vocational Rehabilitation couselor-client approach to problems. After several meetings with the Model Cities personnel, the format to the present project was conceived, and considered to be the best approach to meet the needs of the residents of the Model Cities areas. This demonstration project was an attempt to determine whether or not an intensive family rehabilitation effort would succed in Model Cities areas where previous attempts at implementing Vocational Rehabilitation services were not totally successful. Counselors were to work with the family as a group rather than with individual family members. Along with this, counselors were to be trained in Behavior Modification techniques so that they would be the primary source of service for their clients as opposed to the traditional "purveyor" of service approach. Since the project was terminated at an early stage in its implementation, there is no empirical data on which to base judgments of effectiveness. By December 1971, problems of instrumentation and treatment delivery appeared to have been coped with. Counselors were beginning to observe behavioral changes in some of their clients. (Author/JM)

Intensive Rehabilitation Efforts Toward Total Family Members in Two Characteristically Different Model City Areas

Joseph A. Cote
Project Director

FINAL REPORT

Vocational Rehabilitation Services
State of Rhode Island
Department of Social and Rehabilitative Services

June 4, 1970 - May 31, 1972

Robert Cloward, Ph.D.
Lacey Corbett, Ph.D.
Walter McGinn, Ed.M.
Research Consultants

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ABSTRACT

This demonstration project was an attempt to determine whether or not an intensive family rehabilitation effort would succeed in Model Cities areas where previous attempts at implementing Vocational Rehabilitation services were not totally successful. Counselors were to work with the family as a group rather than with individual family members. Along with this, counselors were to be trained in Behavior Modification techniques so that they would be the primary source of service for their clients as opposed to the traditional "purveyor" of service approach. Unfortunately, though there were some indications of potential with the approach, the project was terminated prior to any significant findings being obtained.

INTRODUCTION

A. Background Information on Project

The project originally began as a direct result of counselor activities and difficulties in the Model Cities areas. The Providence and Pawtucket Model Cities areas proved to be a source of frustration for the counselors involved due to the multiplicity of problems found there and the inadequacy of the usual DVR counselor-client approach to problems. After several meetings with the Model Cities personnel, the format to the present project was conceived, and considered to be the best approach to meet the needs of the residents of the Model Cities areas. Evidence supportive of a different approach for meeting the needs of these individuals is seen throughout the literature. Bagdikian (1965), Marrin (1963), Rude and King (1965), Turner (1964), and Joseph (1956) are several authors who have focused on this problem and presented evidence for changes in present rehabilitation procedures.

The interim report of the Providence Model Cities Program and the comprehensive plan for the Pawtucket Model Cities indicate a great variety of socio-economic, health, crime, housing, recreational and environmental problems. The difficulties encountered in both areas appear to be quite different. Therefore it is felt that a separate elaboration of each city's major problem areas will help to show why the techniques within the basic "holistic model" will have to vary considerably.

The Providence Model Neighborhood is approximately 700 acres in size and is bounded by Broad Street on the West and Interstate Route 95 on the East, North and South. It is predominantly occupied by lower socio-economic class whites and Negroes. The population on non-whites in this area rose 459 percent from 1950 to 1965 and the population on whites decreased 59 percent during the same period. Overall, the population declined from 32,332 to 19,846. By 1968 the population of the model neighborhood had become equally divided between whites and non-whites and it is expected that the percentage of Negroes will increase substantially during the next few years.

The socio-economic problems of the neighborhood are quite severe with 46 percent of all residents earning less than the O.E.O. poverty line. There are also 43 percent of the families in the neighborhood who receive some form of public assistance. Of this group, 71 percent receive aid to families with dependent children. There are 10.7 percent of the non-white and 5,6 percent of the white labor force in the area who are unemployed. An additional 16 percent of the population is underemployed.

The educational level of the neighborhood residents is low, with 33 percent of all adult household heads having less than an eighth grade education and 62 percent of all adults having less than a high school education. Of all school children in Providence who are in the lowest quarter in reading, 44 percent are from the Model Neighborhood. Also at least 6 percent of the school-age population from this area are mentally retarded.

Indications of the family instability such as court disposition of children, illegitimate births and petitions for divorce are all over twice as high in the Model Neighborhood as in the city as a whole.

With regard to crime rates, the Model Neighborhood runs two to three times higher than the city as a whole (raps, murder, robbery, and assault with a deadly weapon). Also, over the past four years, 30 percent of all Providence youths judged wayward or delinquent have come from the Model Neighborhood.

The incidence of lead poisoning, accidental poisoning, draft rejectees, premature births, infant mortality, venereal disease and drug addiction are all extremely high in the Model City area. Finally, over one-fourth of the adult population suffers from some degree of physical or mental disability.

In summary, it can be seen that the Providence Model City has serious deficiencies in the area of education, income, housing, environment, crime and delinquency and health along with a major lack of cohesiveness in the basic unit of society, the family.

The Pawtucket Model Neighborhoods are basically white with over half the population being under twenty-one or over sixty-five. The majority of the families maintain a low income status due to a lack of education and a low level of skills. The former is due to the high value which these people place on work, i.e., they feel that a person should be out working as soon as he reaches the appropriate age. This emphasis on work and lack of emphasis on education has been passed on to their children who represent 32.6 percent of the total number of school dropouts in the city. Therefore, these adolescents wind up in manufacturing jobs as a terminal situation because they lack the skills and education to obtain better employment. Their parents possess skills which are no longer relevant due to the demise of the textile industry. Therefore, they are also locked into manufacturing occupations. In fact, over 60 percent of the Model Neighborhood residents work in manufacturing areas. It is interesting to note that 91.2 percent of the residents have never received any form of job counseling. The result of all of this is that there is an extremely high rate of underemployment in the Pawtucket Model Neighborhoods with the unemployment rate being only about 5 percent. In spite of all this, the morale and motivation to work among the residents is still quite high.

The family unit in the model neighborhood is quite cohesive with the residents not being oriented to a welfare continuum. Only 9.7 percent of the residents receive aid to dependent children as opposed to 49.1 percent who receive this type of payment in Providence.

There is an extreme lack of recreational facilities for adults and adolescents in the Model Neighborhood. This influences the juvenile delinquency rates and contributes to the overall general problems of the area. Ironically, the residents agree that drop-in centers are needed in the area, as long as these centers are not in the immediate proximity of their homes. This fact is disturbing to the youngsters and as a result, the majority of crimes of breaking and entering, vandalism, and car thefts occur in or around the Model Neighborhood.

In regard to the health problems of the area, it is reported that 42 percent of the people have not missed a day of work in the past year. It is also known that 90 percent of the people have their own family doctor; however, they do not see him on any regular basis.

In spite of the above facts, it has been determined that 33 percent of the residents have some form of physical or mental disability.

In summary, the five main problems of the Pawtucket Model areas are: low grade achievement in education, low levels of employment, juvenile delinquency and vandalism, lack of recreational facilities and poor health standards.

Until recently, the residents of both the Providence and Pawtucket Model Cities who were referred to Vocational Rehabilitation for services were seen by different counselors. Because there was no one specific counselor assigned to work exclusively with people from these areas, traditional rehabilitation measures were employed in dealing with these individuals which resulted in a limited rate of success.

As a result, both counselors and clients were frustrated, and numerous cases were closed unsuccessfully due to "lack of motivation and interest," failure to follow through on planning and general apathy. The counselors, because of their middle class orientation, probably failed to realize that the clients from the Model Neighborhood areas had many additional environmental disabilities in addition to the physical or mental problems that brought them to the Vocational Rehabilitation office in the first place.

During the past year, the Agency has done substantial exploratory work to determine the nature of the problems confronting individuals from the Providence Model City area who are potential rehabilitation clients. It was the intention of Vocational Rehabilitation to concentrate on the youthful offenders to develop new attitudes and insight into their behavior.

The lack of an office in the area prevented agency personnel from reaching the out-of-school delinquent population. Attempts to have this type of youngster come to the office were futile. Efforts, therefore, were directed toward working with youngsters in school who were exhibiting predelinquent behavior. Group and individual counseling along with all other agency services were made available to these juveniles and, as a result, it was found that most of the youngsters were staying in school and out of trouble.

Following from a realization of unmet needs in the Model Neighborhood and the ever increasing acceleration of the crime rate in this area, the Vocational Rehabilitation agency applied for and received an Expansion Grant to service the youthful offenders within this area. The juvenile delinquents and predelinquents will be served by a team of professionals who will operate from the new Multi-Purpose Social Service Center currently being established in the Providence Model Neighborhood.

To meet the needs of other individuals in the Model Cities areas called for a change in the traditional role ascribed to the rehabilitation counselor as well as to introduce new techniques to be utilized by the counselors. The primary aim of the project was -- and remained so until the project was abruptly terminated -- to provide direct service to the disabled individual as well as extend services to the remaining members of the family. While this is a significant departure from the

traditional approach, the evidence supporting direct environmental manipulation is warranted in view of the literature in this area. Bernstein (1959), Dishart (1964), Farmer (1968), Freeman and Simmons (1963) and others have commented on the need for comprehensive or "holistic" approaches in rehabilitation agencies. While these refer to "regular" rehabilitation clients -- except for Bagdikian -- it would seem reasonable that individuals and families in the Model Cities areas would need different and more comprehensive approaches than "regular" agency clients.

The second aspect of the project was to limit the number of families to be dealt with, thereby lightening the counselor's caseload. This would allow the counselor to become more of an active agent in the rehabilitation process, i.e., possibly provide more counseling, as opposed to the traditional counselor-coordinator or "broker of services" approach. The inverse relationship between counselor effectiveness and large caseloads is quite evident to anyone who has worked in a rehabilitation setting, and is well documented in the professional literature. Wisconsin and Minnesota studies among others have pointed this out.

Parallel to the second aspect of the project, the need for more direct intervention by the counselors and more professional counseling services, was the rationale behind the addition of supportive training for the counselors. The lack of specialized training for the rehabilitation counselors is well documented in the literature. Patterson (1957), Thomas and Spangler (1964), Hall and Warren (1964), Koch and Meyers (1961) and Thomason and Barrett (1954) are several who have pointed to this problem. Initially, the possibility of using an approach entailing the counselors being trained in Adlerian Family Therapy was considered, however, this was soon dropped mainly due to the lack of any personnel in the area to provide this training and the long-term training involved. As a result, a more practical approach utilizing Behavior Modification methods was adopted. This approach is a relatively new form of treatment based on experimentally derived principles of learning. The major assumption of this procedure is that all abnormal behavior, with the exception of instances of known organic pathology, is due to the faulty learning of the client. Accordingly, any methods used in this approach, are derived from the laboratories of learning and experimental psychology. These methods are primarily conditioning of learning techniques.

Behavioral techniques have been used effectively with many different kinds of behavior problems, such as: attitudinal changes (Bandura, Blanchard, & Ritter, 1968) deviant behavior (Wahler & Ganter, 1969), teaching self-control (Cautela, 1970), and modifying delinquent behavior (Schwitzgehel & Kols, 1964), phobias (Lang & Lazovik, 1963), pervasive anxiety (Cautela, 1967), alcoholism (Lazarus, 1965), were subjected to experimental study, they were found responsible for affecting changes in the behavior problems of adult neurotics, mental defectives (Ray, 1968), adult psychotics (Lindsley, 1956, Ayllon, 1963, Ayllon & Azrin, 1965) and child psychotics (Ferster, 1961; Lovaas et al., 1967).

While there are several conflicting views on the techniques that should be utilized (Diller, 1959; Dyer, 1961; Ellis, 1958; Linde, 1962) there is ample evidence that properly instructed individuals can successfully apply behavioral techniques that will change behavior in more desirable directions. Recent literature includes many clinical reports

of successful "Treatment;" nurses (Ayllon & Michael, 1959); psychiatric aids (Carkhuff & Truax, 1965), college undergraduates (Tharp & Wetzel, 1970), housewives (Rioch et al., 1963) auxiliary counselors (Harvey, 1964), and foster grandparents (Honston, 1967) to name a few.

METHODOLOGY

A. Staffing problem in implementing project

The staff included project director, five counseling positions and initially one consultant; eventually two more consultants were added. The project director and counselors were provided an intensive in-service training program with Dr. Joseph Cautela.

During Dr. Cautela's orientation program, one counselor terminated employment with the agency and this caused some disruption in the orientation program. A new counselor was then hired after the completion of the orientation program. Consequently, this new counselor was not exposed to this rather valuable experience.

During the actual day-to-day operation of the project, Dr. Cautela's orientation program was complemented by weekly meetings with Dr. Lacey Corbett. This included case review and the application of various behavioral modification techniques on an individual case basis. Counselors were also assigned books, various articles and tapes in an effort to give them better insight and understanding of these techniques.

The counselors were assigned to their respective Model City areas -- two were assigned to Pawtucket and three to South Providence. Some initial difficulties in obtaining referrals were eventually overcome after several administrative meetings with Model City personnel.

On June 4, 1970, the project received conditional approval with the stipulation that a revised version of the project had to be submitted by September 1, 1970. To assist us in complying with this directive, on July 16, 1970, we met with Mr. Nathan Ed Acree, Executive Secretary of the General Research Section, and Mr. Anthony Ruscio from the Boston Regional Office. These two gentlemen were quite instrumental in helping us to clarify certain parts of the application. After a mutual exchange of ideas, a revision of the project was completed and resubmitted for approval. On October 2, 1970, a letter from Mr. James F. Garrett, Assistant Administrator of the Office of Research and Demonstration, notified us of the formal approval of the project. We were then enabled to go ahead with full staffing of the project and provision of services for clients.

Under ordinary circumstances, staffing would have been completed within a reasonable period of time. However, on July 1, 1970, the Division of Vocational Rehabilitation was transferred from the Department of Education to a newly created Department of Social and Rehabilitative Services. This contributed greatly to the disruption of the normal hiring routine because of the many adjustments which had to be made within the new department. Also, we had to have five permanent positions changed to temporary because of the nature of the project. In fact, the Project Director's position was not approved until December 14, 1970. In addition to this, a civil service examination for the position of rehabilitation counselor had been given which necessitated the hiring of people who had successfully passed this examination. Many people were interviewed but most of them were not interested in

the positions because they were classified as temporary. Eventually, we were able to fill the positions. All positions were certified and staffing was completed except for the two rehabilitation aides. We were not able to hire rehabilitation aides as these positions were abolished by the Rhode Island Division of Personnel.

B. Behavior Modification Training for Counselors

The training program for Vocational Rehabilitation counselors was divided into two phases. Phase I of staff training consisted of ten weeks and approximately thirty (30) hours of instruction under the direction of Dr. Joseph Cautela. This phase of training was limited to lectures, tapes, and discussions concerning the development, maintenance, and elimination of target behaviors with which the counselor would be confronted. The content of Phase I was subdivided into the following basic areas:

1. Principles of Behavior Modification

The fundamental principles, both classical and operant, and the related self-control techniques as related to disruptive behaviors within the family unit were the primary focus of this phase. During this time, counselors were encouraged to supply examples of behavior problems troublesome to them, and these examples were incorporated into the lectures and discussions.

2. The Development of a Rehabilitation Program

In developing a treatment program for the client, the counselor was trained in behavioral observation, record keeping and quantification skills which were deemed necessary for the application of behavioral modification techniques to specific target behaviors. Various behavior modification techniques were covered in terms of their operant, reciprocal inhibition, and covert conditioning methodologies.

3. Instruction in Behavior Modification Techniques

Group instruction and individual demonstration of the following techniques were provided:

a. Positive Verbal Reinforcement

With this technique, the client is verbally reinforced in an interview setting whenever he performs an adaptive response (e.g., he says he has looked for work), or when he demonstrates the avoidance of a maladaptive response (e.g., stealing or assaultive behavior). When he responds in either of the above ways, the counselor should respond with whatever verbal statement is found to be a reinforcer.

Many clients learn to engage in maladaptive behaviors

for the negative reinforcement which they receive after performing such responses. (e.g., attention from authority objects usually in the form of threats or physical punishment). The administration of positive verbal reinforcement from the counselor for performance of incompatible (adaptive) behaviors has been found to be effective in reducing maladaptive (attention-seeking) behaviors.

Verbal reinforcements may also be given to approximations of the goal behavior when the client does not emit the desired response, but performs a response which could eventually lead to the desired response. This procedure is called "Shaping," (Skinner, 1938), and has been used in various situations to increase new social behaviors.

b. Covert Reinforcement

The counselor may also increase the frequency of pro-social and self-control behaviors by employing the procedure of covert reinforcement (Cautela, 1970). With this technique, the client is asked to imagine that he is making a self-control response (e.g., "I am not going to let my 'wife' (or boss) get to me and lose my temper"). Upon the counselor's signal that the imagery is clear, the counselor speaks the word "reinforcement" and the client immediately imagines a highly (predetermined) reinforcing scene. This self-control technique is extremely versatile and may be applied to both maladaptive avoidance and maladaptive approach behaviors to increase the frequency of any desirable response (Wisocki, 1970).

c. Thought Stopping

This technique is applied to reduce the frequency of undesirable thought, as, "No one will hire me so why bother looking for a job." When the client has these, as well as other maladaptive thoughts or urges, he is instructed to yel, "STOP," in imagination. By using this procedure consistently, the probability of these thoughts or urges decreases. This technique has also been shown to be effective in reducing anxiety-provoking thoughts (Wolpe, 1969) which interfere with learning adaptive behaviors, (e.g., "The guys will think I'm copping out if I don't go with them")

d. Overt and Covert Modeling

In this procedure, the client observes other individuals making adaptive responses, either in vivo (Bandura & Walters, 1959) or in imagination (Cautela, in press). Bandura has shown how children have learned both maladaptive approach and avoidance

behaviors (e.g., various fears, aggressive behavior, stealing) and socially adaptive behavior through such observational process.

e. Relaxation

This procedure is used as a general self-control device. The client is taught a method of relaxing his muscles whenever he is in an anxiety-provoking situation (e.g., a young adolescent becomes very tense when he has to go to school or when he feels that a significant person in his life has rejected him). The "calm" response, experienced from practicing the technique of "relaxation," naturally inhibits the anxiety and the youth is better able to perform a more adaptive behavior (Wolpe, 1958).

f. Desensitization

In this procedure, the counselor constructs a hierarchy of specific stimuli known to evoke fear or anxiety in the client. After being taught relaxation, the client is presented with those stimuli in imagination, beginning with one known to evoke the least amount of anxiety. He is taught how to completely relax in the presence of each fear and is only presented with a greater fear when he experiences no anxiety with the presentation of the previous anxiety stimulus. When the client can imagine, without anxiety, the item which was previously at the top of his anxiety hierarchy (e.g., fear of being called on in class to answer a question with consequent truancy from school (school phobia) (Patterson, 1965; Lazarus, 1960), clients usually find that the anxiety in real life situations has been eliminated.

g. Assertive Training and Behavioral Rehearsal

In these two procedures, the client is taught ways of responding (e.g., "speaking up") appropriately in order to achieve his desired goal. These techniques are particularly useful in individuals whose primary disturbance is manifested in the expression of inappropriate aggression and hostility towards peers or authority figures (Gittelman, 1965).

h. Covert Sensitization

This technique has been shown effective in eliminating such maladaptive approach behaviors as stealing, drug abuse, homosexuality, etc. The procedure consists of pairing the maladaptive behavior with a noxious stimulus as vomiting, insects, etc. in imagination. The client is instructed to imagine himself making an approach response and then being punished for it

with an image of himself engaging in some aversive situation (Cautela, 1970; Cautela & Wisocki, 1971).

Phase II of the training program consisted of weekly individual instruction and supervision of Vocational Rehabilitation counselors by Dr. Lacey O. Corbett. During this phase, specific consideration of program construction began with discussion of how the above-studied techniques would be applied to the target behaviors of the clients within the various family units. Subsequent sessions were devoted to discussing the specific details of implementing behavioral modification programs already developed and to supervising counselors in initiating programs for other family members not yet included in treatment. Behavior modification programs were also constructed to extend to environmental and community situations, i.e., home, school, peer groups, courts, etc. Counselors were encouraged to increase and extend their knowledge of behavioral methods by listening to selected tapes and by assigned readings.

C. Population and Sample

The action program utilized two samples of clients drawn from the Model Cities areas of Providence and Pawtucket. The first experimental sample consisted of 36 clients who applied for Vocational Rehabilitation services between April 1, 1970 and December 31, 1971, and were assigned to the experimental project. The second experimental sample consisted of members of the original applicant's family who were provided Vocational Rehabilitation services under the extended family service treatment. By December 31, 1971, this sample included 18 individuals.

The evaluation plan utilized a third sample as a control group or comparison group for the first experimental sample. The control sample consisted of all of the individuals in the Model Cities areas of the two cities who had applied for and received Vocational Rehabilitation services from general agency counselors (non-experimental) after July 1, 1971. By December 31, this sample included 48 individuals.

It was our intention to accrue cases in all three samples over time and to match cases in sample 1 (initial experimental clients) and sample 3 (control clients) on such variables as the nature of the presenting problem, age, education, sex, and race. Data on control subjects was being collected on an ex post facto basis from agency records. After the Project Director learned of the premature termination of the project, a decision was made to terminate data collection on control subjects accepted for service after November 1, 1971, and to accept no new experimental subjects after December 31, 1971.

Tabulations on relevant matching variables for the accrued experimental and control samples are presented in Table 1. The experimental sample of presenting clients does not differ significantly from the control sample in the distribution of such background variables as sex, race, education, marital status, number of dependents, work status, time on public assistance, and type of disability at referral. On three variables, the differences between the samples are large enough to be statistically significant. The experimental subjects tend to be youngr than the control subjects (median age 21 and 27 respectively) and tend to come from larger families. Control subjects tend to be referred more

often from public welfare agencies. These three factors would need to be taken into consideration in the matching process. Given the current distribution of the background variables and the continued accrual of control cases over time, it seems highly probable that very satisfactory experimental-control matches could have been made.

TABLE I

BACKGROUND DATA ON EXPERIMENTAL (Sample 1) AND CONTROL (Sample 3) SUBJECTS

Age	Experimental	Control
14 - 19 years	17	14
20 - 29 years	9	17
30 - 39 years	7	6
40 - 49 years	1	8
50 years and above	2	3
	36	48
		Chi Square = 6.90*
Sex		
Male	19	30
Female	17	18
	36	48
		Chi Square = 0.80
Race		
White	19	28
Black	16	20
Unknown	1	0
	36	48
		Chi Square = 0.14
Education		
8th grade or less	9	15
9th grade	9	7
10th grade	7	7
11th grade	3	4
12th grade	8	13
Mentally retarded or grade unknown	0	3
	36	48
		Chi Square = 1.89

*Significant at the .05 level of probability.

TABLE I
(Cont'd)

	Experimental	Control
Marital Status		
Married	11	18
Widowed	1	2
Divorced or separated	3	9
Never married	21	19
	36	48
		Chi Square = 0.29
Number in Family		
Two or less	2	19
Three or four	9	15
Five or six	12	7
Seven or more	13	7
	36	48
		Chi Square = 17.05*
Dependents		
None	26	35
One or two	2	6
Three or four	3	4
Five or more	5	3
	36	48
		Chi Square = 1.32
Work Status		
Competitive labor market	3	3
Sheltered workshop	1	0
Homemaker	1	0
Student	14	12
Trainee	2	2
Other	15	30
Not available	0	1
	36	48
		Chi Square = 0.11

*Significant at the .05 level of probability.

TABLE I
(Cont'd)

	Experimental	Control
Public Assistance		
None	18	21
2 years	14	19
3 or more years	3	6
Not available	1	2
	36	48
		Chi Square = 0.14
Source of Referral		
Educational institutions	8	7
Welfare agencies	1	13
Other public institutions	11	9
Private institutions	3	0
Self referral	7	13
Referral by other individual	4	4
	36	48
		Chi Square = 13.86*
Disability at Referral		
Sight or hearing	1	5
Orthopedic or amputation	11	12
Mental problem	13	24
Other physical problem	11	7
	36	48
		Chi Square = 5.23

D. Foci of the Evaluation Study

The evaluation of the project was designed to detect changes in the rehabilitation status, attitudes, and vocational expectations of experimental and control subjects. The main hypothesis to be tested in the study was that subjects experiencing the behavior modification treatment would show greater gains in rehabilitation status, more positive attitudes toward their disabilities, and greater vocational expectations than would control subjects. While we would have been interested, as well, in exploring the differences in the effects of the Behavior Modification treatment as distinct from the effects of the extended family treatment (as an environmental manipulation), these two treatments are comingled in the present design in such a way as to preclude the explorations of hypotheses with regard to their individual effects.

*Significant at the .05 level of probability

The evaluation of therapeutic intervention was also to employ the single subject-within-subject design (Bijou, et al., 1969). This design includes: (1) a period of observation of the behavior frequency (baseline); (2) the introduction of some factor believed to influence the behavior frequency (experimental period); (3) a return to baseline condition (removal of experimental variable); and (4) reintroduction of the influencing factor. While some cases did not lend themselves to this design (particularly those clients with primarily physical handicaps), the early termination of the project limited data collection utilizing this design. Consequently, only a casual relationship may be inferred from the observation wherein reported.

Instrumentation

The Rehabilitation Status Scale, a modified form of the Wisconsin Rehabilitation Gain Scale (Reagles, 1969), was to be administered to experimental and control clients on a prestudy and a poststudy basis. This instrument provides an overall measure of rehabilitation status by assessing attitudes, expectations, current work status, public assistance status, and the kinds of activity in which the client engages. The scale includes twenty items selected from a pool of items on the basis of their internal consistency and dimensionality. The Scale has a reported reliability coefficient of .70 (Reagles, Wright, and Butler, 1970, pg. 23).

While it seemed desirable to have a standardized instrument for the measurement of change, our examination of the Wisconsin Scale has led us to the conclusion that the instrument is excessively loaded with items concerned with avocational and social activities, and underloaded with items concerned with attitudes and expectations. Given the nature of behavior modification and its emphasis on changing attitudes and expectations that undergird maladaptive behavior, it would be quite possible to have changes occur as a result of treatment and not be detected by the Wisconsin Scale.

In the absence of a standardized instrument focused on the area of attitudinal change, the project staff has developed its own instrument the Survey of Feeling. This experimental schedule consists of 18 attitudinal statements indicative of adaptive and maladaptive response tendencies relevant to disabilities in the world of work. For each item, the subject is asked to respond in terms of how often he feels that way (1 very rarely, 2 rarely, 3 sometimes, 4 often, and 5 very often). The Survey yields a total score by reversing the polarity of the weights for negative items and summing over the item weights. The total score, then, represents an ordinal estimate of the total frequency of positive attitudinal response tendencies. Since the instrument is new, its reliability and validity have not been established.

Several more instruments were employed by counselors to delineate problem areas and to identify thoughts and activities that could be effectively used as reinforcements for individual clients. On the Self-rating Behavioral Scale (Cautela) clients were asked to checkmark problem behaviors that they would like to see changed. Two instruments were used to obtain baseline data on the intensity of fear elicited by objects, thoughts, and experiences. The Fear Survey Schedule (Wolpe-Lang) consists of a list of 73 fear provoking objects and activities. The Aversive Scene Survey (Cautela) consists of a short description

of twenty unpleasant situations. Clients were asked to imagine themselves in these situations and to describe the degree of discomfort that they felt. A third instrument, the Job Fear Schedule, was used to identify anxieties associated with employment situations. On all three of these instruments, clients were asked to respond on five point intensity of fear continuum ranging from "not at all" to "very much." These instruments not only helped to delineate the problems and fears of individual clients, but also yielded a total intensity of fear rating by summing response weights over items. While their primary use was that of obtaining baseline data to guide us in structuring the behavior modification treatment for each client, we had planned to re-adminster these schedules at the termination of treatment to further document the effects of the behavior modification intervention.

Finally, the Reinforcement Survey Schedule (Cautela-Kastenbaum) was used to identify objects or activities that are pleasurable and could be used as a means of providing reinforcement for desirable behaviors in the treatment situation. This schedule was administered on a prestudy basis only, and we had no particular plan for using it in the evaluation study.

RESULTS AND DISCUSSION

Since the project was terminated at an early stage in its implementation, we do not have empirical data on which to base our judgments of effectiveness. However, we have had the experience of implementation and have become aware of some of the problems that tend to occur in retraining counselors to deliver a behavior modification treatment.

We observed some resistance on the part of counselors to accepting and using behavior modification techniques. In many respects we were asking the counselors to play roles that were not commensurate with their previous experience and training. Traditionally, the rehabilitation counselor has been prone to play the role of a broker of services. He interviews client, identifies problem areas, determines eligibility, categorizes disabilities, and refers the client for diagnosis and treatment. In short, he tends to purchase for the client the services of other professionals and specialists (doctors, psychiatrists, psychologists, educators, therapists, optometrists, etc.). Having referred the client, the counselor is held responsible only for an occasional monitoring of the case to assess progress.

In the present project, we were asking counselors with only a few weeks of preservice training to play roles that differed markedly from those of the traditional rehabilitation counselor. While no special restrictions were placed on referrals to specialists, the counselor was expected to act himself as a specialist and deliver a behavior modification treatment to the client wherever it seemed appropriate.

With virtually no practical experience in the role of a behavior modifier, the counselors were apprehensive about offering their services to clients in "competition" with highly trained and experienced professionals. They tended to withhold their service until they encountered a client with a suitable disability (often a disability for which no appropriate referral could be found). This tendency was further reinforced by the purely physical or medical nature of some of the problems presented by some of the clients. Counselors often failed to recognize non-medical problems that could be treated by them concurrently with a referral to a medical or physical specialist. Much of the in-service activity of the behavior modification training consultant had to be directed toward helping the counselors recognize treatable problems and helping them gain confidence in their ability to deliver appropriate behavior modification services.

A second problem in the implementation of the project concerned an apparent discrepancy between the stated goal of modifying work-related maladaptive behaviors and the clients' goals of reducing such problem behaviors as stealing, cutting school, using drugs, and so on. Often, it was necessary to focus on these immediate and primary problems of the family before attempting to alter behaviors more directly in line with their seeking and maintaining gainful employment.

A limiting factor in the proposed project was the lack of material (e.g., monetary) reinforcers which could be used contingently in shaping new behaviors for both staff and clients. This problem was most evident in those families living within "project areas," namely, the Roger Williams

Project. For these families the severe lack of previously conditioned ("basic necessities") material reinforcers lessened the response to covert and natural (e.g., free time, using the telephone) reinforcers available for modifying behaviors. Several counselors noted a high frequency of "depressive" like responses for these families. These behaviors consisted primarily of negative statements about themselves and their particular inability to increase positive reinforcements within their respective environments. One counselor stated this problem as follows:

> "The family was just too deprived of basic environmental comforts to be willing to devote enough time to behavioral modification. They were more concerned with their own daily survival..."

There was a notable inconsistency in peer group models and societal (non-peer) expectations regarding approach behaviors to obtaining reinforcement. Not only was there a conditioned expectation for immediate reinforcement but there appeared to be a learned response that reinforcement will follow non-work behavior. For some families it was evident that peer groups have better behavioral control over individual behaviors than other social models. The ability of these clients to obtain reinforcement non-contingent upon appropriate behaviors was a difficult problem to control within the time limits of this project.

Many of those families who lived outside the "project" areas had learned an escape response (i.e., someday they will move out of the area). For these families, delayed reinforcement was more effective in shaping daily adaptive responses and there appears to be some evidence that escape from aversive stimuli was more effective with these clients.

Another problem encountered, was that of maintaining adaptive (self-control) behaviors following initial improvement on target behaviors. Although for several cases the improvement in a target behavior (e.g., reducing "stomach pains") radically altered the relationship between child and the family and school, it was difficult for the counselor to teach parents to maintain reinforcement for these adaptive behaviors.

At times it was difficult to control other experimental variables while introducing behavioral techniques. For example, on one case the client received a change in medication soon after the introduction of the experimental variable (relaxation training).

By December 1971 we had a good grip on the problems of instrumentation and treatment delivery. Counselors were beginning to observe behavioral changes in some of their clients. Client and families, many of whom had experienced unfulfilled hopes and promises in earlier contacts with governmental agencies, were beginning to believe that this project would be different; that promises would be made and kept. It was at this point in time that we learned of the premature termination! As a result of this we can only surmise that the clients whose hopes we raised and subsequently dashed will be even more reluctant to seek and accept further "help" from government agencies.

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DIVISION OF VOCATIONAL REHABILITATION -- SURVEY OF FEELING

Directions:

We want you to answer a few questions as part of a study being conducted by the Division of Vocational Rehabilitation. Your answers will be kept in strictest confidence by the Division.

Here are a list of statements about how some people think or feel. For each statement, indicate how often you feel that way by marking one of the responses.

Name_____ Date_____

Mark How Often You Feel This Way

	Very Rarely	Rarely	Sometimes	Often	Very Often
1. "Most employers don't want to be bothered with you when you have problems like mine."					
2. "Plenty of people with problems like mine have managed to get along quite well."					
3. "With problems like mine, the chances are pretty slim of eventually getting a good job.					
4. "People with problems like mine really don't have much of a future."					
5. "Most employers wouldn't want to have a person with my problems on the pay roll."					
6. "Given a reasonable chance, I feel sure I can succeed."					
7. "Rehabilitation counseling may be o.k. for some people, but I doubt that it would be helpful to me."					
8. "With the kinds of problems that I have, there are very few things that I can do well."					

Mark How Often You Feel This Way

	Very Rarely	Rarely	Sometimes	Often	Very Often
9. "Getting a job to suit your abilities is o.k., but it is never the one you really want."					
10. "Considering the problems I have had, I've managed to get along quite well."					
11. "If they would just give me enough money to live on, I would not care about having a job."					
12. "There is always someone pushing me, trying to make me do better."					
13. "When you have problems like mine, people on the job tend to look down on you."					
14. "It's really quite useless. Things will never get any better."					
15. "I feel sure I have talents that could be useful."					
16. "Sometimes I feel I am my own worst enemy."					
17. "If I were to succeed on a job, the employer would have to make some special arrangements for me."					
18. "Most people don't realize how hard it is to live with the problems that I have."					

Date _____

Name _____

AVERSIVE SCENE SURVEY SCHEDULE (ASSS)*
(Covert Sensitization and Covert Negative Reinforcement)

Try to imagine the following scenes as clearly as possible. Really try to imagine you are there experiencing the scenes. Indicate by a check next to each scene how much discomfort or fear the scene gives you. Even if these scenes are not apt to happen to you, try hard to imagine they are really happening.

1. You are sitting in a dentist's chair and he is about to drill your teeth.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

2. You are tied in a chair and a large gray rat is about to jump on your throat.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

3. The sound of screeching chalk on a blackboard.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

4. A bee landing on your nose.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

5. You have just fallen into a cesspool up to your knees. You can feel your knees and arms all wet and there is an awful stink.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

6. You have just cut your left arm and it is bleeding a great deal.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

7. A snake is wrapped tight around your arms and its head is in front of your face.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

8. By mistake you have just taken a large swallow of vinegar and you feel a very bitter taste in your mouth.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

9. You open a garbage pail and you see and smell worms and maggots crawling all over the sides and bottom.

   not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

10. You are wearing your favorite clothes, a car comes by and splashes mud all over you.

    not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

11. You are walking along and a man walks along next to you. He blows some snots in his hands. He shakes his hands and the snots splatter on your face.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

12. You're at a party talking to some people. Someone says to you, "That's a stupid thing to say," and everybody starts laughing at you.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

13. You are walking across a bridge. There is a loose plank. You fall through and hit the water and injure your leg. You can feel the water going into your nose and lungs, you become very frightened, you feel you are going to drown.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

14. You are walking in a store, you trip over a box and fall into a counter. You and some of the stuff on the counter fall on the floor. Everyone in the store stares at you enjoying your misery.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

15. You are walking down a street late at night and someone comes up behind you and sticks a gun in your back and says, "Stick 'em up!"

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

16. You are walking in the woods and you fall into a hole. Then rocks start to fall on your face and body.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

17. A doctor has just examined you and he says that you need an operation because you might have cancer.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

18. You are in a plane and the pilot announces he will have to make a crash landing in the water.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

19. You are in a movie and then suddenly two men in the row in front of you start fighting with knives.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

20. You find yourself alone, stuck in an elevator. It is completely dark. You shout and bang but nobody hears you. The last person just left the building. You will have to stay in the elevator all night.

not at all ( ) a little ( ) a fair amount ( ) much ( ) very much ( )

SELF-RATING BEHAVIORAL SCALE*

NAME_____ DATE_____

DIRECTIONS: The behaviors which a person learns determine to a large extent how well he gets along in life. Below is a list of behaviors which can be learned. Check the ones which you think you need to learn in order to function more effectively or to be more comfortable.

I need to learn:

_____ 1. To stop drinking too much.

_____ 2. To stop smoking too much.

_____ 3. To stop eating too much.

_____ 4. To control my feelings of attraction to members of my own sex.

_____ 5. To control my feelings of attraction to members of the opposite sex.

_____ 6. To overcome my feelings of nausea when I'm nervous.

_____ 7. To stop thinking about things that depress me.

_____ 8. To stop thinking about things that make me anxious.

_____ 9. To feel less anxious in crowds.

_____ 10. To feel less anxious in high places.

_____ 11. To stop worrying about my physical condition.

_____ 12. To feel less anxious in airplanes.

_____ 13. To stop stuttering.

_____ 14. To stop washing my hands so often.

_____ 15. To stop cleaning or straightening things up so often.

_____ 16. To stop biting my fingernails.

_____ 17. To take better care of my physical appearance.

_____ 18. To feel less anxious in enclosed places.

_____ 19. To feel less anxious in open places.

_____ 20. To feel less afraid of pain.

_____ 21. To feel less afraid of blood.

_____ 22. To feel less anxious about contamination or germs.

_____ 23. To feel less anxious about being alone.

_____ 24. To feel less afraid of the darkness.

_____ 25. To feel less afraid of certain animals.

_____ 26. To stop thinking the same thoughts over and over.

_____ 27. To stop counting my heartbeats.

_____ 28. To stop hearing voices.

_____ 29. To stop thinking people are against me or out to get me.

_____ 30. To stop seeing strange things.

_____ 31. To stop wetting the bed at night.

_____ 32. To stop taking medicine too much.

_____ 33. To stop taking too many pills.

_____ 34. To stop taking dope.

_____ 35. To stop having headaches.

_____ 36. To control my urge to gamble.

_____ 37. To be able to fall asleep at night.

_____ 38. To control my desire to expose myself.

_____ 39. To control my desire to put on clothing of the other sex.

_____ 40. To control my feelings of sexual attraction to other people's clothing or belongings.

_____ 41. To control my sexual feelings toward young children.

_____ 42. To control my desire to hurt other people or to be hurt.

_____ 43. To control my desire to steal.

_____ 44. To control my tendency to lie.

_____ 45. To stop daydreaming a lot.

_____ 46. To control my desire to yell at or hit other people when I'm angry.

_____ 47. To manage money better so that I have enough for what I really need.

_____ 48. To stop saying "crazy" things to other people.

_____ 49. How to carry on a conversation with other people.

_____ 50. To feel more comfortable carrying on a conversation with other people.

_____ 51. To stop bugging other people too much.

_____ 52. To be less forgetful.

_____ 53. To stop thinking about committing suicide.

_____ 54. To control my urge to set fires.

_____ 55. To hold down a steady job.

_____ 56. To feel comfortable on my job.

_____ 57. To stop swearing at other people.

_____ 58. How not to be upset when others criticize me.

_____ 59. To speak up when I feel I'm right.

_____ 60. To stop putting off things that need to be done.

_____ 61. To stop thinking so much about things that make me feel guilty.

_____ 62. To feel less anxious when my work is being supervised.

_____ 63. To feel less anxious about sexual thoughts.

_____ 64. To feel less anxious about kissing.

_____ 65. To feel less anxious about petting.

_____ 66. To feel less anxious about sexual intercourse.

_____ 67. To be able to make decisions when I have to.

_____ 68. To feel at ease just being with other people in a group.

_____ 69. To feel at ease talking with other people in a group.

_____ 70. To feel less anxious about _____.

_____ 71. To feel less guilty about _____ _____.

_____ 72. To control my desire to _____.

_____ 73. To change my _____ _____.

* Upper and Cautela

Wolpe & Lang
FEAR SURVEY SCHEDULE

Name_____ Date_____

The items in this questionnaire refer to things and experiences that may cause fear or other unpleasant feelings. Write the number of each item in the column that describes how much you are disturbed by it nowadays.

How much you Dislike

	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH	
1. Noise of vacuum cleaners (N)						1.
2. Open wounds (T)						2.
3. Being alone (C)						3.
4. Being in a strange place (M)						4.
5. Loud voices (N)						5.
6. Dead people (T)						6.
7. Speaking in public (C)						7.
8. Crossing streets (C)						8.
9. People who seem insane (T)						9.
10. Falling (M)						10.
11. Automobiles (C)						11.
12. Being teased (S)						12.
13. Dentists (T)						13.
14. Thunder (C)						14.
15. Sirens (N)						15.
16. Failure (M)						16.
17. Entering a room where other people are already seated (S)						17.
18. High places on land (C)						18.
19. People with deformities (T)						19.
20. Worms (A)						20.
21. Imaginary creatures (M)						21.
22. Receiving injections (T)						22.
23. Strangers (S)						23.
24. Bats (A)						24.

How much you Dislike

	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH	
25. Journeys (C) a. Train b. Bus c. Car						25.
26. Feeling angry (M)						26.
27. People in authority (S)						27.
28. Flying insects (A)						28.
29. Seeing other people injected (T)						29.
30. Sudden noises (N)						30.
31. Dull weather (M)						31.
32. Crowds (S)						32.
33. Large open spaces (C)						33.
34. Cats (A)						34.
35. One person bullying another (T)						35.
36. Tough looking people (S)						36.
37. Birds (A)						37.
38. Sight of deep water (C)						38.
39. Being watched working (S)						39.
40. Dead animal (T)						40.
41. Weapons (M)						41.
42. Dirt (C)						42.
43. Crawling insects (A)						43.
44. Sight of fighting (T)						44.
45. Ugly people (S)						45.
46. Fire (C)						46.
47. Sick people (T)						47.

Wolpe & Lang
FEAR SURVEY SCHEDULE
(Cont'd)

How much you Dislike	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH	
48. Dogs (A)						48.
49. Being criticized (S)						49.
50. Strange shapes (M)						50.
51. Being in an elevator (C)						51.
52. Witnessing surgical operations (T)						52.
53. Angry People (S)						53.
54. Mice (A)						54.
55. Blood (T)						55.
a. Human						a.
b. Animal						b.
56. Parting from friends (S)						56.
57. Enclosed places (C)						57.
58. Prospect of a surgical operation (T)						58.
59. Feeling rejected by others (S)						59.
60. Airplanes (C)						60.
61. Medical odors (T)						61.
62. Feeling disapproved of (S)						62.
63. Harmless snakes (A)						63.
64. Cemeteries (T)						64.
65. Being ignored (S)						65.
66. Darkness (C)						66.
67. Premature heart beats (T) (missing a beat)						67.
68. (a) Nude Men (S)						68.a
(b) Nude Women						b
69. Lightning (C)						69.
70. Doctors (T)						70.

Wolpe & Lang
FEAR SURVEY SCHEDULE
(Cont'd)

How much you Dislike	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH	
71. Making mistakes (M)						71.
72. Looking foolish (S)						72.
73. a. Your own death b. The death of others						73. a b

Name_____

JOB FEAR SURVEY SCHEDULE

Please rate below how much anxiety or displeasure you feel for each item listed.

	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH
1. The first day on a job					
2. Being supervised					
3. Collecting your paycheck					
4. Noise					
5. Being changed to a new job					
6. A new person at work					
7. Being alone					
8. Loud voices					
9. Presenting a report of your work					
10. Being teased					
11. Failing at some task					
12. Entering a room with other people present					
13. Coming late to work					
14. Eating lunch in a group					
15. Eating lunch alone					
16. High places					
17. Crowded places					
18. Sirens					
19. Falling					
20. Travelling					
21. Feeling angry					

JOB FEAR SURVEY SCHEDULE
(Cont'd)

	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH
22. People in authority					
23. Dull weather					
24. Large open spaces					
25. Sudden emergencies					
26. Hearing another person being criticized					
27. Tough looking people					
28. Being watched working					
29. Dirt					
30. Ugly people					
31. Chance of fire					
32. Calling in sick					
33. Being criticized by a colleague					
34. Being criticized by a supervisor					
35. Being in an elevator					
36. Angry people					
37. Rats					
38. Working with machines					
39. Feeling rejected					
40. Strange odors					
41. Making mistakes					
42. Being ignored					
43. Looking foolish					
44. Getting hurt on the job					
45. Being absent from work					

JOB FEAR SURVEY SCHEDULE

	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH
46. Giving people orders					
47. Telling someone he is doing a poor job					
48. Firing someone					
49.					
50.					

TABLE I
REINFORCEMENT SURVEY SCHEDULE FOR CHILDREN

The item in this questionnaire refer to things and experiences that may give joy or other pleasurable feelings. Check each item in the column that describes how much pleasure it gives you nowadays.

	NO	YES	VERY MUCH
Section 1.			
EATING			
Ice Cream			
Candy			
Fruit			
Cake			
Nuts			
Cookies			
BEVERAGES			
Water			
Milk			
Soft drinks (coke, pepsi, 7-up,etc)			
Tea			
Coffee			
SOLVING PROBLEMS			
Cross Word puzzles			
Mathematical problems			
Figuring out how something works			
LISTENING TO MUSIC			
Classical			
Western Country			
Jazz			
Show Tunes			
Rhythm & Blues			
Rock & Roll			
Folk			
Popular			

REINFORCEMENT SURVEY SCHEDULE FOR CHILDREN
(Cont'd)

	NO	YES	VERY MUCH
ARTS AND CRAFTS			
Coloring			
Drawing			
Painting			
Working with clay			
Model cars or airplanes			
Cutting paper dolls			
Working with felt & other cloth materials			
ANIMALS			
Dogs			
Cats			
Horses			
Birds			
Section II **WATCHING SPORTS**			
Football			
Baseball			
Basketball			
Hockey			
Track			
Golf			
Swimming			
Running			
Tennis			
Bowling			
Other			

REINFORCEMENT SURVEY SCHEDULE FOR CHILDREN
(Cont'd)

	NO	YES	VERY MUCH
READING			
Adventure			
Mystery			
Famous People			
Poetry			
Travel			
Politics & History			
How-to-do-it			
Humor			
Comic Books			
Love Stories			
Religion			
Sports			
Medicine			
Science			
Newspapers & magazines			
Fairy Tales			
Looking at interesting buildings			
Looking at beautiful scenery			
T.V., movies or radio			
LIKE TO SING			
Alone			
With others			
LIKE TO DANCE			
Rock & Roll			
With a partner (boy or girl)			
Ballet			

REINFORCEMENT SURVEY SCHEDULE FOR CHILDREN
(Cont'd)

	NO	YES	VERY MUCH
LIKE TO DANCE (Cont'd)			
Square dancing			
Folk dancing			
Performing on a musical instrument			
Playing with puppets			
Hitting a punching bag or dummy			
PLAYING SPORTS			
Football			
Baseball			
Basketball			
Hunting			
Hockey			
Golf			
Swimming			
Running			
Tennis			
Bowling			
Boxing			
Judo or Karate			
Fishing			
Skin-diving			
Auto or cycle racing			
Hunting			
Skiing			
Target Practice and archery			
Yo-Yo			

REINFORCEMENT SURVEY SCHEDULE FOR CHILDREN
(Cont'd)

	NO	YES	VERY MUCH
SHOPPING FOR			
Clothes			
Toys			
Records			
Sports Equipment			
Food			
Playing Cards			
Hiking or walking			
Completing a difficult job			
Camping			
Sleeping			
Taking a bath			
Taking a shower			
BEING RIGHT			
Guessing what somebody is going to do			
In an argument			
About your work			
On a bet			
BEING PRAISED			
About the way you look			
About your work			
About your hobbies			
About your physical strength			
About your athletic ability			
About your mind			
About your personality			

REINFORCEMENT SURVEY SCHEDULE FOR CHILDREN
(Cont'd)

	NO	YES	VERY MUCH
DOING SCHOOLWORK			
Reading			
Spelling			
Social Studies			
Math			
Science			
Friends wanting to be with you or play with you			
Talking with people who like you			
Making somebody happy			
Babies			
Younger children			
Older children			
Having people ask your advice			
Watching other people			
Somebody smiling at you			
Happy people			
Talking to friends			
Being perfect			
Winning a bet			
Being in a church or a temple			
Saying prayers			
Peace and quiet			
Quiet games			
Being close to nice men			
Being close to nice ladies			